Medicaid Quality Control

Reducing Errors in Medicaid Payments

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Medicaid: Health Care for Needy People

Medicaid is a Federal/State program that finances health care for some 25 million needy people. Authorized by Congress in 1965, Medicaid is administered by the States in accordance with Title XIX of the Social Security Act and Federal regulations. At the Federal level, the Medicaid Bureau of the Health Care Financing Administration (HCFA), under the Department of Health, Education, and Welfare, oversees the Medicaid program.

Currently, Medicaid costs over $19 billion annually. The Federal Government's share averages 55 percent, with State and local governments paying 45 percent. All States (except Arizona) and the U. S. Territories of Guam, Puerto Rico, and the Virgin Islands, participate in Medicaid. Each designs and administers its own Medicaid program, subject to broad Federal guidelines and monitoring.

States pay providers of medical services for the care that Medicaid-eligible recipients receive. Such payments may not exceed reasonable and customary charges or reasonable costs, as determined by the State Medicaid agency.

All recipients of Aid to Families with Dependent Children (AFDC) and most Supplemental Security Income (SSI) beneficiaries are eligible for Medicaid. Also, in about half the States and territories, the "medically needy"—persons who do not receive cash assistance but meet income and resource requirements for medical services—are eligible.

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Spending Medicaid Dollars Properly

In a large, national program such as Medicaid, errors can result in wasting of public funds. It is estimated that hundreds of millions of Medicaid dollars are paid in error.

Taxpayers, as well as State legislators and administrators, and members of Congress have expressed concern over how Medicaid dollars are spent. Among the questions often asked:

- Is Medicaid administered fairly and efficiently?
- Is Medicaid providing coverage to eligible people?
- Are all Medicaid payments made correctly?

To answer these questions and to be sure that Medicaid funds are properly used, the Medicaid program must first determine what the situation is in each State: what kinds of errors are most common, what costs are associated with these errors. Then remedial action is taken.

HCFA and the State Medicaid agencies are responsible for the proper and efficient administration of the Medicaid program.

Kinds of Payment Errors

Ineligibility is the foremost cause of Medicaid payment errors. Medicaid eligibility is defined by State and Federal law and policy, with State agencies responsible for making the actual eligibility determination. Such determinations can be quite complex, depending not only on the individual or family's income and resources, but also on their projected utilization of medical services, family or individual circumstances and special needs.

To avoid payment of claims for ineligible persons, it is important that recipients cooperate in providing accurate and timely information needed to determine their eligibility,

and that State agency staff collect and handle the data with skill and accuracy.

A number of circumstances can cause the payment of claims for ineligible persons. Among these are:

- Failure to verify an applicant's income and resources
- Renewing eligibility without rechecking the recipient's situation
- Paying for medical services which should have been paid for by the beneficiary

Third-party liability is another source of errors. Under law, Medicaid is the "last payor" after other liable "third-parties" have paid for medical care and services for a Medicaid enrollee. Before paying, States have not always checked to see if a recipient's bills should be paid, in whole or part, by Medicare, workmen's compensation, private health insurance, another public agency, a health maintenance organization or an estate. A study in one State showed that, in nearly 20 percent of Medicaid claims, there was third-party liability. Through subsequent efforts, millions of dollars were recovered from third parties at an administrative cost of only 12 percent of the monies recovered.

Improper processing of Medicaid claims can result in payment errors. Payment may be made for unauthorized services, to uncertified providers or for amounts above the allowable fee level. In some cases, duplicate payments have been made for a single service.

Quality Control in Medicaid

Medicaid Quality Control (MQC) is a systematic, coordinated effort by State and Federal governments to assure proper, efficient administration of the program. Begun in 1975, MQC uses a statistical monitoring system to detect the level of incorrect payments due to the three types of errors described above, so that corrective action can be taken.

Medicaid and other social programs borrowed quality control (QC) techniques from business, which uses them to minimize flaws in products and services. HEW first employed QC in 1964 to find and reduce errors in the AFDC program. By 1973, any States that did not have QC programs to cut error rates in AFDC were subject to Federal penalty, and HEW set minimum error tolerances for AFDC. In 1974, when programs of aid to the aged, blind and disabled were Federalized to become the SSI program, QC methods were included from the start to reduce misspent dollars.

MQC: How It Works

As in industry quality control programs, Medicaid judges the overall quality of its "products" (cases) by inspecting a statistically valid sample. This technique is more economical and just as valid as examining all cases.

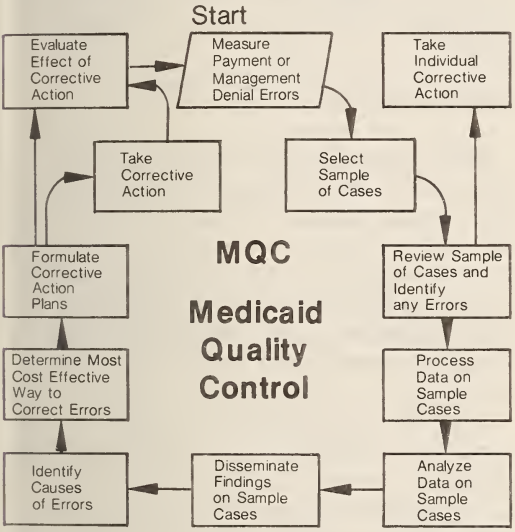
Monthly, each State selects a sample of its certified Medicaid-eligible cases for review. Nationally, the sample is 78,000; each State has a prescribed sample size that reflects the size of its Medicaid caseload and an expectation that the sample findings will be accurate to the 95 percent confidence level. The selection is now made from the total Medicaid recipient population (before April 1, 1978, however, the sample was drawn only from among medically needy recipients).

First, the eligibility of all case members for the review month is verified. Then, Medicaid claims submitted for any individual included in the sampled case during that month are checked (Analysis of a case, which begins in the month following the review month, is not completed until eight months following the end of the period. This is done to ensure that most claims connected with the case have been submitted and paid.) Additionally, claims in each sample case are reviewed for:

- Third-party liability;

- Correctness of claim, including the dollar amount;
- Possible duplication of claims; and
- Whether provider is approved by State to provide Medicaid services?

Because the present sample is representative of the total caseload, information obtained from the sample can be projected to all Medicaid eligibles. For example, if 10 percent of the cases in the sample are found ineligible, it is projected that 10 percent of the State's total cases are ineligible


Start
Evaluate Effect of Corrective Action
Measure Payment or Management Denial Errors
Take Individual Corrective Action
Take Corrective Action
Select Sample of Cases
MQC
Medicaid Quality Control
Formulate Corrective Action Plans
Review Sample of Cases and Identify any Errors
Determine Most Cost Effective Way to Correct Errors
Process Data on Sample Cases
Identify Causes of Errors
Disseminate Findings on Sample Cases
Analyze Data on Sample Cases

Semi-annually, following computer analysis of data from the sample cases, MQC reports a case error rate and a dollar error rate for each State. By comparing the 6-month rate to rates for the previous 6-month period and to national rates, the Medicaid program can determine trends in error rates, analyze what causes errors and plan how to avoid them.

A comparable sample of 14,000 cases is picked from all cases that are turned down or terminated. This "negative case action" sample is reviewed for errors in which the Medicaid agency has incorrectly terminated or denied Medicaid coverage. Thus, both

types of mistakes are measured: error leading to incorrect payments and incorrect denials and terminations.

Using the Case Approach

Since April 1, 1978, HCFA has used Medicaid **cases** rather than **claims** as the basis for its quality control sampling. A case may consist of an individual or a family.

Eligibility errors, which make up the largest source of payment errors, can be detected more quickly and accurately when all cases for a given month are sampled, rather than sampling claims, for which eligibility may have been determined many months previously.

Who Operates MQC?

Each State Medicaid agency operates its own quality control system, following a uniform plan designed by HCFA. Trained State QC staff make full investigations of sample cases, documenting and verifying each element of eligibility, third-party liability and claims processing and may include face-to-face interviews with all adult recipients involved.

Federal QC staff then examine a subsample of the State-reviewed cases to verify the accuracy of the findings. HCFA periodically publishes Medicaid error rates and results of the States' efforts to reduce program error.

HCFA provides guidance and help to State Medicaid agencies, including detailed instructions and guidelines for sampling and other quality control procedures. The Institute for Medicaid Management (IMM) offers training for State Medicaid staffs, facilitiates the exchange of ideas on Medicaid and spotlights effective State practices. IMM conducts conferences and workshops and issues a journal and other publications relating to Medicaid management.

Taking Corrective Action

When mispayment is found through the

QC process, the State Medicaid agency is required to take corrective action—immediate steps to correct the errors found and minimize their recurrence and long-term action to rectify the causes.

First, any errors in the sample cases must be corrected. Usually, the case is reopened, eligibility redetermined and steps taken to recover misspent funds. The State agency must determine whether an error resulted from willful misrepresentation by the recipient or provider and if so, whether legal action should be instituted.

However, most payment errors point to the need for improved management practices by State Medicaid agencies. To assist in this, HCFA has developed a technical assistance task force: the **Corrective Action Project (CAP).** CAP staff specialists are knowledgeable in eligibiliy and claims processing management, third-party benefit recovery and QC data analysis for planning corrective action.

In cooperation with Medicaid regional offices, CAP staff work with the States to design corrective action projects tailored to the needs and resources of each State. They also join State staff in implementing or field-testing operational improvements and evaluating their effect. CAP staff often work onsite with the States and may call upon other States with similar experience, other Medicaid Bureau offices and outside consultants, as needed.

Among the ways CAP staff help State staff to improve Medicaid management practices in a State are:

- Expand programs to recover benefits from responsible third parties;
- Improve intake forms and procedures and client information systems to reduce eligibility errors;
- Use casework staff more efficiently by analyzing staff caseload ratios, setting performance standards and identifying kinds of cases, claims and

providers most likely to generate errors.

- Improve staff training and dissemination of State instructions to field staff.
- Help beneficiaries become more responsible by giving them more readable forms, notices and other printed information.
- Analyze and where needed, improve claims' processing methods to minimize erroneous payments.

For Further Information

More information on the Medicaid Quality Control program can be obtained from the Medicaid Quality Control Unit of any of the ten HEW Health Care Financing Administration regional offices (in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco and Seattle) or from:

Medicaid Bureau
Health Care Financing Administration
Department of HEW
Baltimore, MD 21235

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